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ABSTRACT

The matching hypothesis, presented in this study, predicts that designing treatment according to patient characteristics leads to better outcomes. A study was conducted to collect data on current practices of patient-treatment matching in alcohol treatment. A questionnaire was completed by 70 directors of Veterans Administration inpatient alcohol treatment programs. The highest rate of matching was reported for marital and family problems. The rates of matching for the treatment of other drug use, psychopathology, and sexual dysfunction reflected the prevalence of these problems among individuals presenting for alcohol treatment. The data on posttraumatic stress disorder (PTSD) were consistent with the high frequency of drug and alcohol problems in individuals with PTSD. The preliminary results of the survey revealed a range of program components and a range of patients using components when they were available. These results, combined with responses to direct questions about screening practices and matching for the treatment of specific problem areas, suggest that there is a high rate of matching done in the context of inpatient alcohol treatment and for a wide variety of problem areas. (NB)

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THE RELATIONSHIP BETWEEN ASSESSMENT AND ALCOHOL TREATMENT

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THE RELATIONSHIP BETWEEN ASSESSMENT AND ALCOHOL TREATMENT

A number of excellent reviews of alcohol treatment outcome research have led to the conclusion that staying in treatment is associated with improvement in different areas of functioning. However, a finding of differential treatment effectiveness has proved more elusive. Another result of outcome research is that characteristics of the person receiving treatment often account for as much or more of the variance in his or her posttreatment functioning than do treatment experiences. These two findings together suggest a way to increase the effectiveness of treatment experiences: conform the treatment to the person's characteristics. The matching hypothesis explanation of failures to find differential treatment effects predicts that designing treatment according to patient characteristics leads to better outcomes.

Several authors (e.g., Skinner, 1981) have commented that the research data on Patient by Treatment matching support the matching hypothesis. However, another question is how, if at all, matching influences the current delivery of alcohol treatment under routine circumstances. Unfortunately, there are not much data bearing directly on this problem. One of the few published studies was completed by Bromet, Moos, Wuthmann, and Bliss (1977). This paper concerned a substudy of a major outcome project that included five residential alcohol treatment programs and a sample of 505 patients. Characteristics of the patients were correlated with their treatment experiences within each program. The patient characteristics included demographic variables such as age, sex, marital status, residential stability, and social class; drinking severity, defined as ratings on factors like age at onset of uncontrolled drinking, quantity of alcohol consumed, and

physical concomitants of drinking; and recent psychological functioning, based on patients' responses to scales measuring depression, anxiety, self-esteem, and self-ratings of their problem. A total of 15 treatment experiences were encoded though each program did not necessarily include each type of treatment experience. Examples of treatment experiences were antianxiety medication, individual or group therapy, and occupational therapy. Patient characteristics also were correlated with patient length of stay. Separate analyses for each program showed no relationship between any patient characteristics and treatment experiences or length of stay. These findings are not encouraging to anyone who views patient-treatment matching as a way to increase alcohol treatment effectiveness. Furthermore, the data are puzzling in view of clinicians' frequent statements that matching patients to treatment is standard practice for them.

The paucity of data raises a considerable need for investigation of the practices of patient-treatment matching in alcohol treatment programs. Such data are the foundation of improved clinical services and of group studies of the effects on outcome of matching treatment to patients. The purpose of this study, therefore, was to collect survey data on current practices of patient-treatment matching in alcohol treatment. This pilot survey is part of a larger research program on matching and clinical judgement in alcohol treatment.

Method

A questionnaire and cover letter describing the purpose of the study was sent to each of 113 directors of V.A. inpatient alcohol treatment programs. Respondents were also sent a self-addressed envelope with postage for return of their questionnaires. The programs were selected

among the listings in The National Directory of Drug Abuse and Alcoholism Treatment and Prevention Programs (USDHHS, 1985).

A total of 81 of the 113 questionnaires was returned through the initial and one follow-up request, for a response rate of 72%. Of the 81 questionnaires, 70 had complete data. A follow-up series of phone calls to the programs that did not respond to either of the two requests revealed that five of them were drug programs and thus did not respond to the questionnaire. This brought the total response rate to 74%. The response rate for completed questionnaires was 64%.

Results

Program Characteristics

The mean number of beds (Slide 1) in this sample of inpatient programs was 32.5, with a range of 12-97 beds. The average duration of programs (Slide 2) with a fixed length of stay was 28.1 days, and the range was 14-42 days. Programs with a varied length of stay averaged a minimum of 14.8 days and a maximum of 33.3 days. The average length of stay in these programs was about 24 days.

The next two slides (Slides 3 and 4) are a summary of the data on program components and the frequency of patients who were exposed to each component in the last three months. The data show, first, that a variety of program components, including those for treatment of other addictive behaviors, was available to patients. Furthermore, in the last three months a wide range of patients used a component when it was available. The programs that are asterisked extend the range of available treatment services, but because these data were generated by the respondent's adding them to the "other" category the statistics cannot be interpreted in the same way as for components listed in the questionnaire.

As can be seen in the next slide (Slide 5) program staff were dominated by nursing personnel and alcohol and drug counselors. Staff and their Program Director most often followed the disease model of alcoholism (Slide 6) although other models of alcoholism were also represented. In addition, frequently more than one model of alcoholism was reported to represent the staff or the Director's beliefs about alcoholism. On the average, there was a fairly small discrepancy between the Program Director's and his or her staff's beliefs about alcoholism, at least from the Director's point of view.

Matching

The next slide (Slide 7) shows that matching at the molar level of screening for program admission is done by a large majority of the programs. As can be seen in Slide 8, the method used most frequently for screening was the interview. Standardized questionnaires were also often available for screening, but the proportion of patients who were assessed with them was not high. Relatedly, it was surprising that only 61.4% of the programs reported that they used standardized alcohol questionnaires and, in those programs, only 43.7% of the patients were assessed in the last three months by that method. Physiological measures, such as blood alcohol concentration and liver function tests, were used for screening in only a few programs.

The patients who did not meet a program's criteria for admission were referred to a number of dispositions (Slide 9). The disposition reported most frequently was AA. Of interest is that few individuals did not get referred to some type of treatment setting or program.

The data suggested that programs are also matching at a high rate for specific problem areas once patients are admitted to a program (Slide 10). Matching was reported for the treatment of a number of problem areas

(Slide 11), although again the data must be interpreted with some caution since they are based on self-generated responses. By far, the highest rate of matching was reported for marital and family problems, a finding that is consistent with increased emphasis on such problems in alcohol treatment. Similarly, the rates of matching for the treatment of other drug use, psychopathology, and sexual dysfunction reflect the prevalence of these problems among individuals presenting for alcohol treatment. The data on post-traumatic stress disorder are consistent with the high frequency of drug and alcohol problems in individuals with PTSD.

As was found for screening, matching for the treatment of specific problem areas was most dependent on the interview (Slide 12). Consistent with expectations, standardized personality tests and tests of special functions (e.g., neuropsychological evaluation) were available in fewer of the programs.

Discussion

The preliminary results of this pilot survey suggest that, consistent with clinicians' reports, there is a high rate of matching done in the context of inpatient alcohol treatment and for a wide variety of problem areas. This conclusion is supported by the range of program components and the range of patients using components when they were available, as well as by direct questions about screening practices and matching for the treatment of specific problem areas.

Obviously, there are several limitations in our data. They are based on unvalidated reports of program directors who may have an interest in showing more patient-treatment matching than really occurs, despite our efforts to reduce that demand characteristic. Furthermore, the data are limited to inpatient V.A. alcohol programs, and their generalizability to

to other treatment settings, like private hospital inpatient or outpatient, remains to be demonstrated. Nevertheless, our data suggest that matching is done at a high rate even in treatment programs that are typically quite structured.

The initial findings raise questions that may be answered both in our present data and in the data of later studies. For example, it is of interest to know whether program variables such as size and staff characteristics are associated with matching practices. Another important point concerns the process of coordinating assessment and treatment planning. In this regard, part of our data consist of single program analyses. It seems that for many programs several assessment methods might be used for treatment of a given problem area. One program reported the use of seven different methods to assess anxiety. Using multiple methods of assessment is good clinical practice; the question is how decisions to use particular assessments are made and then how the resulting data combined to formulate treatment plans. A full understanding of matching and alcohol treatment requires investigation of this question.

In summary, our descriptive data offer a glimpse of the practice of matching treatment to patients in alcohol programs. These data are a foundation of further survey research and of experimental studies of clinicians' decision making in using data to guide treatment.

References

Bromet, E., Moos, R., Wuthmann, C., & Bliss, F. (1977). Treatment experiences of alcoholic patients: An analysis of five residential alcoholism programs. The International Journal of the Addictions, 12, 953-958.

Skinner, H.A. (1981). Different strokes for different folks: Differential treatment for alcohol abuse. In R.E. Meyer et al. (Eds.), Evaluation of the alcoholic: Implications for research, theory, and treatment (pp. 349-367). Washington D.C.: U.S. Government Printing Office.

Slide 1

Number of Beds

MEAN	32.49
MINIMUM	12
MAXIMUM	97

N = 63

Slide 2

Length of Stay

A. FIXED LENGTH OF STAY = 61.43% (43/70)

Mean = 28.16

Minimum = 14.00

Maximum = 42.00

B. VARIABLE LENGTH OF STAY = 34.29 (24/70)

Mean of minimum = 14.79 (range = 1-30)

Mean of maximum = 33.25 (range = 7-56)

Mean = 24.02

Slide 3

COMPONENT	% OF PROGRAMS OFFERING PROGRAMS	FREQUENCY OF PATIENTS WHO RECEIVE COMPONENT	
ALCOHOL HEALTH EDUCATION	100.00	98.71	(10.00-100.00)
MILIEU THERAPY	90.00	96.19	(0.00-100.00)
NUTRITION EDUCATION	98.57	95.80	(10.00-100.00)
SELF HELP GROUPS	100.00	92.71	(0.00-100.00)
LEISURE OR RECREATION	95.71	90.15	(10.00-100.00)
PHYSICAL/EXERCISE PROGRAM	95.71	87.54	(0.05-100.00)
COMMUNICATION/SOCIAL SKILLS	90.00	83.33	(0.00-100.00)
ANXIETY OR STRESS MANAGEMENT	98.57	82.75	(0.00-100.00)
INDIVIDUAL COUNSELING	97.14	82.35	(0.00-100.00)
PROCESS COUNSELING	67.14	78.51	(0.00-100.00)
VOC./OCCUPATIONAL COUNSELING	98.57	67.10	(10.00-100.00)
POLYDRUG ABUSE	92.86	58.62	(0.00-100.00)
ACTIVITIES OF DAILY LIVING	71.43	57.00	(0.00-100.00)
DETOXIFICATION	62.86	42.15	(0.00-100.00)
ART THERAPY	52.43	40.00	(0.00-100.00)
COUPLE/FAMILY COUNSELING	100.00	38.71	(0.00-100.00)
ANTABUSE	100.00	38.01	(0.00-100.00)
WEIGHT MANAGEMENT	72.86	27.65	(0.00-100.00)
POST TRAUMATIC STRESS DISORDER	68.57	24.38	(0.00-100.00)
SMOKING CESSATION	55.71	19.31	(0.00-100.00)
PSYCHOTROPIC MEDS	90.00	14.21	(0.00- 90.00)
GAMBLING CONTROL	45.71	4.69	(0.00- 30.00)

Slide 4

COMPONENT	PERCENT OF PROGRAMS OFFERING COMPONENT	FREQUENCY OF PATIENTS WHO RECEIVE COMPONENT	
		MEAN	RANGE
*CYBERNETICS	1.43	100.00	(100.00-100.00)
*GROUP THERAPY	10.00	100.00	(100.00-100.00)
*COGNITIVE/BEHAVIORAL THERAPY	1.43	100.00	(100.00-100.00)
*JOURNAL WRITING	1.43	100.00	(100.00-100.00)
*VOLUNTEER WORK	1.43	100.00	(100.00-100.00)
*DISCHARGE PLANNING	2.86	100.00	(100.00-100.00)
*TRANSACTIONAL ANALYSIS	1.43	100.00	(100.00-100.00)
*PSYCHODRAMA	1.43	100.00	(100.00-100.00)
*COMMUNITY LIVING ADAPTATION	1.43	100.00	(100.00-100.00)
*RESPONSIBILITY COUNSELING	1.43	100.00	(100.00-100.00)
*FINANCIAL PLANNING	1.43	100.00	(100.00-100.00)
*MUSIC	1.43	100.00	(100.00-100.00)
*PRE-BED HOUSING	1.43	100.00	(100.00-100.00)
*RELAPSE PREVENTION	8.57	90.00	(50.00-100.00)
*SPIRITUAL COUNSELING	15.71	80.91	(30.00-100.00)
*PROBLEM SOLVING	4.29	80.00	(50.00-100.00)
*MOOD MANAGEMENT	2.86	70.00	(40.00-100.00)
*THERAPEUTIC	1.43	70.00	(70.00- 70.00)
*ANGER MANAGEMENT	2.86	70.00	(40.00-100.00)
*PSYCHOLOGICAL TESTING & FEEDBACK	4.29	70.00	(10.00-100.00)
*VALUES CLARIFICATION	2.86	65.00	(30.00-100.00)
*WIVES OR SIGNIFICANT OTHER GRPS	1.43	50.00	(50.00- 50.00)
*DESENSITIZATION/PHOBIAS	1.43	30.00	(30.00- 30.00)
*ACOA GROUP	2.86	30.00	(30.00- 30.00)
*LEGAL COUNSELING	1.43	30.00	(30.00- 30.00)
*DEPRESSION	1.43	20.00	(20.00- 20.00)
*SEXUAL COUNSELING	1.43	10.00	(10.00- 10.00)

STAFFING

POSITION	MEAN #	RANGE
REGISTERED NURSE	4.26	.000-20.50
ALCOHOL/DRUG COUNSELOR	3.61	.000-12.00
NURSING ASSISTANT	2.31	.000-32.00
LICENSED PRACTICAL NURSE	1.52	.000- 7.00
SOCIAL WORKER	1.51	.000- 6.00
CLINICAL/COUNSELING PSYCHOLOGIST	1.18	.000- 4.00
PSYCHIATRIST	.90	.000- 3.50
OTHER PHYSICIAN	.42	.000- 3.00
*PHYSICIAN ASSISTANT	.32	.000- 5.00
*VOC/OCCUPATIONAL THERAPIST	.23	.000- 3.00
*NURSE PRACTITIONER	.12	.000- 3.00
*PROGRAM DIRECTOR OR COORDINATOR	.11	.000- 1.00
*PSYCHOLOGY TECHNICIAN	.11	.000- 4.00
*RECREATIONAL THERAPIST	.09	.000- 2.00
*SOCIAL WORK ASSOCIATE	.03	.000- 2.00
*HEALTH OFFICER	.03	.000- 1.00
*CHAPLAIN	.02	.000- .50
*RESIDENTS	.02	.000- 1.50
*VOLUNTEER	.02	.000- 1.00
*HALFWAY HOUSE DIRECTOR	.01	.000- 1.00
*OUTREACH DIRECTOR	.01	.000- 1.00
*PSYCHOLOGY INTERN	.01	.000- 1.00
*MARITAL OR FAMILY THERAPIST	.01	.000- 1.00
*DIETICIAN	.01	.000- .25
*PHYSICAL THERAPIST	.002	.000- .12

Slide 6

MODELS

MODEL	%YES DIRECTOR	% YES STAFF
DISEASE	82.9	85.7
BEHAVIORAL/SOCIAL LEARNING	68.6	62.9
FAMILY SYSTEMS	54.3	52.9
SOCIALOGICAL/CROSS CULTURAL	34.3	28.6
PSYCHODYNAMIC	32.9	25.7
HUMANISTIC	15.7	18.6
MORAL	1.4	5.7
*ECLECTIC	4.3	2.9
*BIOLOGICAL/GENETIC	1.4	0.0
*BIOPSYCHOSOCIAL	1.4	2.9
*PSYCHOSOCIAL	1.4	1.4
*AA	1.4	1.4
*HOLISTIC	1.4	0.0

Slide 7

DO YOU USE CRITERIA TO SCREEN INDIVIDUALS PRIOR TO ADMISSION?

61/70 = 87% checked "YES"

Slide 8

ASSESSMENT METHOD	% of Programs That Use Method	Frequency of Patients Who Are Assessed	
		Mean	Range
STRUCTURED INTERVIEW	81.43	78.60	(.00-100.00)
UNSTRUCTURED INTERVIEW	67.14	76.17	(.00-100.00)
REVIEW OF PAST RECORDS	87.14	75.08	(.00-100.00)
MENTAL STATUS EXAM	84.29	73.05	(.00-100.00)
DEMOGRAPHIC FACTORS	70.00	68.16	(.00-100.00)
INTERVIEW WITH FAMILY OR SIGNIFICANT OTHERS	82.86	37.41	(.00-100.00)
STANDARDIZED ALCOHOL QUESTIONNAIRE	61.43	43.72	(.00-100.00)
STANDARDIZED PERSONALITY TESTS	65.71	34.13	(.00-100.00)
STANDARDIZED TESTS OF SPECIFIC PROBLEMS	55.71	22.56	(.00-100.00)
STANDARDIZED TESTS OF DEPRESSION OR ANXIETY	55.71	21.03	(.00-100.00)
*MEDICAL EXAM	7.14	60.00	(.00-100.00)
*LIVER, BLOOD, LAB TESTS	5.71	50.00	(.00-100.00)
*NEUROPSYCHOLOGY	8.57	45.00	(.00-100.00)
*BLOOD ALCOHOL CONCENTRATION	4.29	33.33	(.00-100.00)
*MILIEU ASSESSMENT	4.29	33.33	(.00-100.00)
*AA & NA PARTICIPATION	4.19	30.00	(.00-100.00)
*STANDARDIZED IQ TESTS	7.14	22.00	(.00-100.00)
*DRUG SCREEN	4.29	16.67	(.00-100.00)
*VOCATIONAL TESTS	4.29	3.33	(.00-100.00)

Slide 9

Disposition of Patients Who Were Screened and Refused Admission

	Mean	Range
REFERRAL TO COMMUNITY RESOURCES LIKE AA	32.36	(.00-100.00)
NO REFERRAL SINCE PATIENT REFUSED ANY TREATMENT	20.44	(.00-100.00)
REFERRAL TO OUTPATIENT ALCOHOL TREATMENT PROGRAMS	20.08	(.00-100.00)
REFERRAL TO INPATIENT OR OUTPATIENT PSYCHIATRIC TREATMENT PROGRAM	13.82	(.00- 50.00)
REFERRAL TO INPATIENT OR OUTPATIENT TREATMENT FOR DRUG ABUSE	11.56	(.00- 60.00)
REFERRAL TO ANOTHER INPATIENT ALCOHOL TREATMENT PROGRAM	11.31	(.00-100.00)
REFERRAL TO HALFWAY HOUSE	4.59	(.00- 50.00)
NO REFERRAL SINCE PATIENT HAD NO SUBSTANCE ABUSE PROBLEM	3.57	(.00- 50.00)
*DROPOUT	1.93	(.00- 67.00)
*REFERRAL TO DETOX FACILITY	1.20	(.00- 45.00)
*REFERRAL FOR MEDICINE	.98	(.00- 50.00)
*RETURN TO REFERRAL SOURCE	.98	(.00- 30.00)
*REFERRAL FOR MORE SCREENING IN SAME PROGRAM	.08	(.00- 5.00)
*INELIGIBLE	.08	(.00- 5.00)
*REFERRAL TO DOMICILE	.05	(.00- 3.00)

Slide 10

DO PATIENTS RECEIVE DIFFERENT INTERVENTIONS FOR ANY SPECIAL PROBLEMS THAT THEY MAY HAVE?

85.7% Checked "YES"

Slide 11

	Match For Problem Areas	Of The Programs That % of Programs That Match For Problem Areas
MARITAL/FAMILY	72.9	85.0
DEPRESSION	44.3	57.7
ANXIETY	34.3	40.0
PSYCHOPATHOLOGY	31.4	36.7
VOCATIONAL	31.4	36.7
VIOLENCE, ANGER, IMPULSE CONTROL	25.7	30.0
OTHER DRUG USE	24.3	28.3
SEXUAL DYSFUNCTION	21.4	25.0
MEDICAL/DENTAL	20.0	23.3
POST TRAUMATIC STRESS	18.6	21.7
SOCIAL OR COMMUNICATION SKILLS	18.6	21.7
SPIRITUALITY	17.1	20.0
ORGANIC/NEUROPSYCHOLOGICAL	15.7	18.3
CHILDREN OF ALCOHOLICS	12.9	15.0
SCHIZOPHRENIA/THOUGHT DISORDER	10.0	11.7
RESIDENTIAL PLACEMENT	7.1	8.3
VALUES CLARIFICATION	7.1	8.3
OVEREATING	7.1	8.3
LEISURE ACTIVITY	5.7	6.7
SMOKING	5.7	6.7
GAMBLING	5.7	6.7
RELAPSE	4.3	5.0
PHYSICAL FITNESS	4.3	5.0
EDUCATIONAL NEEDS	4.3	5.0
DEATH & DYING/GRIEF	4.3	5.0
MINORITY ISSUES/SPECIAL POPULATION	2.9	3.3
ACTIVITIES OF DAILY LIVING SKILLS	2.9	3.3
ECONOMIC PROBLEMS	2.9	3.3
SOCIAL NETWORK PROBLEMS	2.9	3.3
SLEEP	1.4	1.7
LEGAL PROBLEMS	1.4	1.7

Slide 12

ASSESSMENT METHODS	OF ONLY THOSE PROGRAMS THAT MATCH, % OF PROGRAMS THAT USE ASSESSMENT METHOD
UNSTRUCTURED INTERVIEW	73.3
STRUCTURED INTERVIEW	70.0
STANDARDIZED PERSONALITY TESTS	56.7
INTERVIEW WITH FAMILY OR SIGNIFICANT OTHER	56.7
REVIEW OF PAST RECORDS	51.7
NEUROPSYCHOLOGICAL TESTS	31.7
STANDARDIZED TESTS OF PROBLEM AREAS	31.7
STANDARDIZED TESTS OF INTELLIGENCE	30.0
STANDARDIZED TESTS OF DEPRESSION OR ANXIETY	28.3
STANDARDIZED ALCOHOL QUESTIONNAIRE	11.7
*PHYSICAL OR MEDICAL EXAM	20.0
*LAB TESTS	11.7
*UNSTRUCTURED GROUP	6.7
*CHAPLAINS	5.0
*BIOFEEDBACK	5.0
*INTAKE QUESTIONNAIRE	5.0
*PSYCHOSOCIAL EVALUATION	5.0
*WARD BEHAVIOR	1.7
*MEDICATION EVALUATION	1.7
*DIETICIAN'S	1.7
*DENTAL EXAM	1.7
*SLEEP EVALUATION	1.7
*OUTSIDE AGENCY EVALUATION	1.7
*SEXUAL DYSFUNCTION EVALUATION	1.7